08750

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH:

County: Prince Georges

City or town: Glenn Dale Md (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 11 mos 23 days

Hospital, institution, or street address where death occurred: Glenn Dale Sanatorium

How long in hospital or institution? 11 mos 23 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: D.C. County:

City or town: Washington D.C. (If outside city or town limits, write RURAL and give nearest town)

Street No. 2417 - 17th ST Apt 2 (If rural, give LOCATION)

2.(a) If veteran, name war: no

3. (a) FULL NAME: Charles Newton Alexander

3. (b) Social Security Number: none

4. Sex: male

5. Color or race: colored

6.(a) Single, married, widowed, or divorced: widowed

6.(b) Name of husband or wife: Olivia Alexander deceased

6.(c) If alive, give age: ? years

7. Birth date of deceased (mo., day, yr.): ?

8. AGE: Years 44 | Months 6 | Days 5 | If less than one day ..... hrs. ..... min.

9. Birthplace: Chestertown Maryland (Town, county, and state)

10. Usual occupation: Janitor - Porter

11. Industry or business:

FATHER
12. Name: Thos Alexander
13. Birthplace: Md

MOTHER
14. Maiden name: Eliz Jane Young
15. Birthplace: Md

16. Informant: Deceased

Address: 2417 - 17th St Apt #2

17. Removal (Burial, cremation, or removal. Which?) Date thereof 8/26/1940 (month) (day) (year)

Cemetery or crematory:

Location: Washington

18. Funeral director: Daniel Davis

Address: 1432 Vt. St. N.W.

19. 8/26 1940 (Date rec'd by registrar) Leo V. Almeida M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 25th 1940 at 9 03 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 2nd 1939, to Aug 25th 1940 and that I last saw him alive on Aug 25th 1940

Immediate cause of death: Pulmonary Tuberculosis — DURATION: 11 mos

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results: Pulmonary Tuberculosis

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D. M. D. or other

Address: Glenn Dale Sanatorium Date signed 8/28/40

Glenn Dale, Md.

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
SEP 3 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(937)

08751

CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH:

County: Pro Georges Co.

City or town: Riverdale Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 19 years

Hospital, Institution, or street address where death occurred: 505 Monroe St

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Pro Geo Co

City or town: Riverdale Md

(If outside city or town limits, write RURAL and give nearest town)

Street No. 505 Monroe St

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME John O. Angevine

3. (b) Social Security Number

4. Sex: male

5. Color or race: white

6.(a) Single, married, widowed, or divorced: married

6.(b) Name of husband or wife: Florence M Angevine

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Sept 7 1859

8. AGE: Years 79 (10) Months — (11) Days — (12) If less than one day — hrs. — min.

9. Birthplace: New York (Town, county, and state)

10. Usual occupation: Pressman

11. Industry or business: Govt Printing Office

FATHER 12. Name: Eljah Angevine

13. Birthplace: N Y

MOTHER 14. Maiden name: Maria Vetof

15. Birthplace: N Y

16. Informant: Florence M Angevine

Address: Riverdale Md

17. Transportation (Burial, cremation, or removal, Which?) Date thereof: Aug 27/1940 (month) (day) (year)

Cemetery or crematory: Paterson New Jersey

Location: Patterson N.J.

18. Funeral director: F Gasch's sons

Address: Hyattsville Md.

19. Aug 26 1940 (Date rec'd by registrar) Wm Norgk LOCAL Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 8-24 1940, at 11 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2-15 1940, to 8-24 1940 and that I last saw him alive on Aug 20 1940

Immediate cause of death: Myocarditis

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

DURATION: 1 yr

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Lucian Hays M. D. or other

Address: Hyattsville Md Date signed: 8-24-40

VS A15

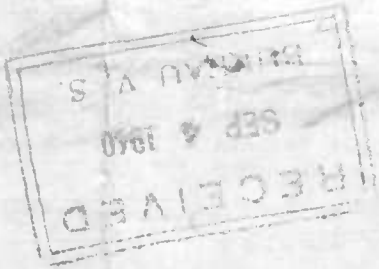
MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Moore Funeral Co.,
Patterson N.J.

(Crum)

RECEIVED
SEP 4 1940
BUREAU V. S.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

08994

CERTIFICATE OF DEATH

Reg. Dist. No. 235

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Prince Georges.
City or town Forestville md.
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 20 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Pr. Geo
City or town Forestville Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Lottie Armstrong

3. (b) Social Security Number

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
F	W	single

6 (b) Name of husband or wife
6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 9

8. AGE: Years	Months	Days	If less than one day
94	9		hrs. min.

9. Birthplace N. Y. (Town, county, and state)
10. Usual occupation none
11. Industry or business
FATHER 12. Name Osten J. Armstrong
13. Birthplace N. Y.
MOTHER 14. Maiden name Mary A Burns
15. Birthplace Scotland
18. Informant Mrs Josephine Peterson
Address Forestville md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 8-23-40 (month) (day) (year)
Cemetery or crematory Mt Calvert
Location Forestville md.
18. Funeral director W W Chambers.
Address 517-11 st S E.
19. 8/21 1940 Thos D Griffith
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 21 1940, at 7 45 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1 1940 to Aug 21 1940
and that I last saw her alive on Aug 20 1940

Immediate cause of death Mild Acute cystitis. — DURATION 3 days

Due to Malnutrition and Secondary Anemia

Due to General Arteriosclerosis and Chronic interstitial Nephritis

Other conditions Progressive Senile Changes

(Include pregnancy within 3 months of death)

Major findings:
Of operations none
Of autopsy none

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: —
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work? —

23. SIGNATURE Hans C Van Hatten M. D.
Address Bennings D.C. Date signed Aug 21 1940.

RECEIVED
NOV 6 1940
BUREAU U. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08752
243
Reg. Dist. No.

1. PLACE OF DEATH:
County: Prince Georges
City or town: Glenn Dale
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 9 mo - 26 days
Hospital, Institution, or street address where death occurred:
Glenn Dale Sanatorium
How long in hospital or institution? 9 mo 26 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D. C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2209 - 9th St. N.W.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME Peyton Beverly

3.(b) Social Security Number 577-12-7445

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	Separated

6.(b) Name of husband or wife: Mary Beverly
6.(c) If alive, give age: 67 years

7. Birth date of deceased (mo., day, yr.): Feb 24, 1879

8. AGE: Years	Months	Days	If less than one day
61	7	27	....hrs. ....min.

9. Birthplace: King George Co, Virginia (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business: —

FATHER
12. Name: unknown
13. Birthplace: King George Co, Virginia

MOTHER
14. Maiden name: Lucy Beverly
15. Birthplace: King George Co, Virginia

16. Informant: Mary Beverly (wife)
Address: 613 M St. N.W.

17. Removal (Burial, cremation, or removal. Which?) Date thereof: Aug 24/40 (month) (day) (year)
Cemetery or crematory:
Location: Washington - Dc.

18. Funeral director: W. Ernest Lee
Address: 1432 You St N.W.

19. Aug 24 1940 (Date rec'd by registrar) Leo V. Allwine M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 23 1940, at 3:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 27 1939, to August 23 1940
and that I last saw him alive on August 23 1940

Immediate cause of death	DURATION
Pulmonary Tuberculosis	1 yr - 8 mo
Due to	23 d.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ....Date of op.....
Autopsy results: Pulmonary Tuberculosis
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ....Date of.....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): .....
Means of injury: Injured at work?

23. SIGNATURE: Daniel Lee Duncan M.D. M. D. or other
Address: Glenn Dale Sanatorium Date signed: 8/27-40
Glenn Dale, Md.

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
SEP 2 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

94a

08753

Reg. Dist. No. 245

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Pr Geo County
City or town: Hyattsville Md
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: 7 md ave
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days): 40 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Pro Geo Co
City or town: Hyattsville Md Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 7 md ave
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Orvilla M Bresnahan
3. (b) Social Security Number: no

4. Sex: female
5. Color or race: white
6. (a) Single, married, widowed, or divorced: widower
6 (b) Name of husband or wife: maurice F Bresnahan sr
6(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): Oct 6, 1940 1660
8. AGE: Years: 59 yrs | Months: 10 | Days: 25 | If less than one day: hrs. min.
9. Birthplace: washington DC (Town, county, and state)
10. Usual occupation:
11. Industry or business: Housewife
FATHER 12. Name: Martin Van Buren matthews
FATHER 13. Birthplace: New york
MOTHER 14. Maiden name: Virginia Taylor
MOTHER 15. Birthplace: Md
16. Informant: Ruby Bresnahan
Address: 7 md ave - Hyattsville Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: sept 4, 1940 (month) (day) (year)
Cemetery or crematory: Ft Lincoln
Location: washington DC
18. Funeral director: L Gasch's sons
Address: Hyattsville Md
19. Sept 11 (Date rec'd by registrar) 19 40 Mrs Jas Devere (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 31, 1940, at 7.45 P. M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 1 1939, to Aug 31 1940
and that I last saw h alive on 19
Immediate cause of death: Acute Coronary Thrombosis — DURATION: 8/31
Due to: Coronary Thrombosis — Aug 1939
Due to: Stenosis — July 1940
Other conditions:
(Include pregnancy within 3 months of death)
Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE: Maurice Bresnahan M. D. or other
Address: Riverdale — Date signed: 8/31/40

RECEIVED
OCT 5 1940
BUREAU V. S.

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08754

Reg. Dist. No. 243

1. PLACE OF DEATH:

County: Prince Georges

City or town: Rural - Glenn Dale, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 mo. 15 da.

Hospital, Institution, or street address where death occurred: Glenn Dale Sanatorium

How long in hospital or institution? 8 mo. 15 da.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D.C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1533 Bell's Court, N.W.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Jerome Brice

3. (b) Social Security Number: None

4. Sex: Male

5. Color or race: Colored

6.(a) Single, married, widowed, or divorced: Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Feb. 8, 1894

8. AGE: Years: 46 Months: 6 Days: 2 If less than one day: hrs. min.

9. Birthplace: Cartersville, Va.
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business:

FATHER
12. Name: Randolph Brice
13. Birthplace: Unknown

MOTHER
14. Maiden name: Ellen Jackson
15. Birthplace: Unknown.

16. Informant: Jerome Brice
Address: 1533 Bell's Court, N.W., Washington, D.C.

17. Removal (Burial, cremation, or removal. Which?) Date thereof: Aug 10, 1940 (month) (day) (year)

Cemetery or crematory: Arlington Cem.

Location: Arlington, Va.

18. Funeral director: Ernest [illegible]
Address: 1432 You St. N.W.

19. August 10 1940 (Date rec'd by registrar) Leo V. Almeida M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 10 1940, at 2.45 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 25 1939, to Aug. 10 1940 and that I last saw him alive on Aug. 10 1940

Immediate cause of death: Pulmonary Tuberculosis

Due to:

Due to:

Other conditions: Acute Generalized Miliary Tuberculosis
(Include pregnancy within 3 months of death)

DURATION
9 mos.
7 ds.

Major findings of operations:

Date of op.

Autopsy results: Acute Generalized Miliary Tuberculosis

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Daniel Lee Finucane M.D. M. D. or other

Address: Glenn Dale Sanatorium Date signed

Glenn Dale, Md.

RECEIVED
AUG 21 1940
BUREAU V. S.

STATE OF MARYLAND—CERTIFICATE OF DEATH

08755

131-6

1. PLACE OF DEATH

County Prince George Registration Dist. No. 239

Village or City Laurel No. St., 11th Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred 71 yrs. 3 mos. 12 ds. How long in U.S. if of foreign birth? yrs. mos. ds.

2. FULL NAME William Henry Brown If U.S. Veteran, specify WAR

(a) Residence: No. 203 — 11th St Laurel Md Ward.

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Lucretia Brown

6. DATE OF BIRTH (month, day, and year): May 2, 1869

7. AGE: Years 71 | Months 3 | Days 12 | If LESS than 1 day, hrs. or min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc.

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.: Laborer

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country): Laurel Md

FATHER

13. NAME: James Brown

14. BIRTHPLACE (city or town) (State or country): Maryland

MOTHER

15. MAIDEN NAME: Mary Shorts

16. BIRTHPLACE (city or town) (State or country): Maryland

17. INFORMANT (Address): Lucretia Brown 11th St Laurel Md.

18. BURIAL, CREMATION, OR REMOVAL

Place: Cry Hill Date: Aug 17, 1940

19. UNDERTAKER (Address): Ridgley Selby 401 Washington Laurel Md

20. FILED: Aug 16, 1940 M. Brashears Deal Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH: August (Month) 14 (Day), 1940 (Year)

22. I HEREBY CERTIFY, That I attended deceased from 7 28, 1940, to 8 14, 1940

I last saw him alive on 8 14, 1940; death is said to have occurred on the date stated above, at 5 30 p m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

	Date of onset
Arteriosclerosis	1929
Chr. Nephritis	1935
Chr. Myocarditis	1935

Other Contributory Causes of importance:

Auto Cardiac Dilatation	8 14 40

Name of operation Date of

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? Date of injury, 19

Where did injury occur? (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) B. P. Warren M. D.

(Address) Laurel Md

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

RECEIVED SEP 3 1927 BUREAU

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (64-C)

CERTIFICATE OF DEATH

08756

Reg. Dist. No. 232

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Prince Georges

City or town Upper Marlboro

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Crane Highway

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) Life

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince Georges

City or town Upper Marlboro Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Mary Leaf Butler

3. (b) Social Security Number

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Female	Colored	Widowed

6 (b) Name of husband or wife William Thomas Butler

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1871

8. AGE:

Years	Months	Days	If less than one day
69			hrs. min.

9. Birthplace Brandywine Md (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Own Home

FATHER 12. Name Isaac Norman

FATHER 13. Birthplace Md

MOTHER 14. Maiden name —

MOTHER 15. Birthplace Md

16. Informant William J. Butler

Address Upper Marlboro Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug. 24-40, (month) (day) (year)

Cemetery or crematory Mt. Carmel

Location Upper Marlboro, Md.

18. Funeral director Pitchie Brothers

Address Upper Marlboro, Md.

19. Aug 23 1940 (Date rec'd by registrar) Carl Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 21 1940, at 3:30 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19, to 19, and that I last saw h alive on 19.

	DURATION
Immediate cause of death Hemorrhage Shock	
Due to Gunshot Wound Through Chest	
Due to	
Other conditions	
(Include pregnancy within 3 months of death)	

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Suicide Date of 8-21-40

Where did injury occur? Upper Marlboro (City or town) Prince Georges (County) Md (State)

Injured at home, farm, industry, public place (where?) home

Means of injury Gunshot Injured at work? No

23. SIGNATURE James D. Bond M. D. or other

Address Forestville Md Date signed 8-21-40

RECEIVED
SEP 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore (93d)

08757

CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH:
County: Prince George
City or town: College Park Md
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: University Lane
Stay in hospital or inst. (yrs., or mos., or days): —
Stay in this community (yrs., or mos., or days): 12 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Pro Geo Co
City or town: College Park Md Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: University Lane
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: William Perry Cissel

3. (b) Social Security Number:

4. Sex: Male
5. Color or race: White
6. (a) Single, married, widowed, or divorced: Widower
6 (b) Name of husband or wife: Ida Cissel
6(c) If alive, give age: 74 years
7. Birth date of deceased (mo., day, yr.): D.C.

8. AGE: Years: 74 Months: 1 Days: 5 If less than one day: hrs. min.

9. Birthplace: ~~Brick Layer~~ D.C. (Town, county, and state)
10. Usual occupation: ~~Building~~ Bricklayer
11. Industry or business: Building

FATHER
12. Name: Edward Cissel
13. Birthplace: Md

MOTHER
14. Maiden name: Annie Crawford
15. Birthplace: Md

16. Informant: Alton Cissel
Address: College Park Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 25/1940 (month) (day) (year)
Cemetery or crematory: Evergreen
Location: Bladensburg Md

18. Funeral director: F. Gasch's Sons
Address: Bladensburg Md

19. Aug 26 1940 (Date rec'd by registrar) F. Mc Norgle LOCAL Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 24. 1940, at 5:30 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 7 1940, to Aug 24. 1940, and that I last saw him alive on Aug 24 1940.

Immediate cause of death: Acute Cardiac Dilation — DURATION: 8/24/40
Due to: Myocarditis Chr. — ?
Due to: — ?
Other conditions: Arterio Sclerosis. — ?
(Include pregnancy within 3 months of death)
Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Martin Keane M. D. or other
Address: Riverdale Md Date signed: 8/24/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
SEP 4 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-E)

CERTIFICATE OF DEATH

08758

Reg. Dist. No. 245

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Prince Georges Co.
City or town: Hyattsville. Md.
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Mother Joans Rest Home
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days): I Week.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Washington. County: D.C.
City or town: Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 1513 Rhode Island Ave N.W.
(If rural give LOCATION)
2(c) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Emma Coith.

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single.

6 (b) Name of husband or wife:
6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): I/5/88

8. AGE: Years	Months	Days	If less than one day
82	7	13	hrs. min.

9. Birthplace: Germany. (Town, county, and state)
10. Usual occupation: None
11. Industry or business: None

FATHER
12. Name: Theo.
13. Birthplace: Germany.

MOTHER
14. Maiden name: Louise Seahuman.
15. Birthplace: Germany.

16. Informant: Mrs L.M. Burgess.
Address: Hyattsville Md.

17. Removal. Wash. D.C. Date thereof 8/18/40
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory: Cedar Hill Cemetery
Location:

18. Funeral director: M. G. Huntsmann
Address: 5732 Georgia Ave N.W.

19. August 18 1940 Mrs. Jay Severe
(Date rec'd by registrar) Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 8/18/40 19 40, at 12 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 13 1938, to Aug 18 1940, and that I last saw h alive on Aug 17 1940.

Immediate cause of death: Cerebral Thrombosis — DURATION: Unknown

Due to: Arterio-Sclerosis

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causee, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Bernard L. Trench M. D. or other
Address: 1726 M St. N.W. Date signed 8.18.40
Wash. D.C.

RECEIVED
SEP 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (95-C)

CERTIFICATE OF DEATH

08759

Reg. Dist. No. 231

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Prince Georges
City or town: Bladensburg
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: 13 Bryant Ave.
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days): 6 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: County:
City or town: Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.:
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Porter Burkes Cox

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

B (b) Name of husband or wife: William A. Cox
6(c) If alive, give age: 85 years

7. Birth date of deceased (mo., day, yr.): Feb. 28, 1862

8. AGE:

Years	Months	Days	If less than one day
78	6	29	hrs. min.

9. Birthplace: Lynchburg, Campbell, Virginia
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER
12. Name: William Rice Scott
13. Birthplace: Lynchburg, Va.

MOTHER
14. Maiden name: Virginia Louisa Burkes
15. Birthplace: Arnolds Valley Va.

16. Informant: Margaret Cox Harris
Address: 13 Bryant Ave.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 30 1940 (month) (day) (year)
Cemetery or crematory: Scott
Location: Lynchburg Va

18. Funeral director: Ft. Davis Sons
Address: Bladensburg Md

19. Aug 29 1940 (Date rec'd by registrar) Mrs Wright LOCAL Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 27, 1940 19 ..., at 1:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 27, 1940 19 ..., to Aug. 27, 1940, and that I last saw her alive on August 27, 1940 19 ...

Immediate cause of death	DURATION
Acute Dilatation of Heart	1 minute
Due to Congestive Heart Failure	Unknown
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations: None
Of autopsy: None

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: None Date of:
Where did injury occur? None (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Charles C. Hagage M. D.
M. D. or other
Address: Mount Rainier, Md. Date signed: 8/29/40

RECEIVED
SEP 4 1940
BUREAU V. S.

08760

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

CERTIFICATE OF DEATH

Reg. Dist. No. 239

1. PLACE OF DEATH:

County Prince George

City or town Laurel Md.

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 320 Talbott

Stay in hospital or inst. (yrs., or mos., or days) —

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince George

City or town Laurel Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. 320 Talbott Ave.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR —

3. (a) FULL NAME Emma Barbara Crook

3. (b) Social Security Number —

4. Sex F.

5. Color or race W.

6. (a) ~~Single, married~~, widowed, or ~~divorced~~ Widowed

B (b) Name of husband or ~~wife~~ Wm H. Crook

B(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Mar 26, 1857

8. AGE: Years 83 | Months 4 | Days 8 | If less than one day ____ hrs. ____ min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Home

FATHER

12. Name Wm C. Orr

13. Birthplace Washington, Pa.

MOTHER

14. Maiden name Ellen E. Huston

15. Birthplace East Liverpool, Ohio

16. Informant Carlyle Crook

Address Laurel Md.

17. Burial (Burial, ~~cremation, or removal. Which?~~) Date thereof Aug. 20, 1940 (month) (day) (year)

Cemetery or crematory Loudon Park

Location Baltimore Md.

18. Funeral director DeWitt Donaldson

Address Laurel Md.

19. Aug 20 1940 (Date rec'd by registrar) M. Brashears Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 18, 1940 19 ____, at 8P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8-16-1940, to 8-18-1940, and that I last saw her alive on 8-18-40 19 ____.

Immediate cause of death Arteriosclerosis

Due to Chr. Myocarditis

Due to Acute Cardiac Dilatation

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

DURATION

7, 2, 40

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide ____ Date of ____

Where did injury occur? ____ (City or town) ____ (County) ____ (State)

Injured at home, farm, industry, public place (where?)

Means of injury ____ Injured at work?

23. SIGNATURE B. [illegible] M. D. or other

Address Laurel Md. Date signed 8. 1940

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
SEP 3 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (97)

CERTIFICATE OF DEATH

08761

Reg. Dist. No. 245

1. PLACE OF DEATH:

County: Prince George

City or town: Hyattsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 9 yrs.

Hospital, institution, or street address where death occurred: Sacred Heart Home

How long in hospital or institution? 9 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 835 Fulton St.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME Elizabeth Cunningham

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Jan 27, 1861

8. AGE: Years 79 | Months 7 | Days 4 | If less than one day ..... hrs. ..... min.

9. Birthplace (Town, county, and state) Washington DC.

10. Usual occupation Seamstress

11. Industry or business

FATHER — 12. Name John Cunningham

13. Birthplace Ireland

MOTHER — 14. Maiden name Margaret Hughes

15. Birthplace Ireland

16. Informant Rev. Sister Beatrice

Address 415 N. Biddle Ba. Md

17. (Burial, cremation, or removal. Which?) Burial Date thereof 9-3-40 (month) (day) (year)

Cemetery or crematory Calvary

Location Balto Md

18. Funeral director Joseph A. Farley

Address Catonsville

19. Aug 31 1940 (Date rec'd by registrar) Medically Served Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 31 1940, at 3:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 14 1939, to Aug 31 1940

and that I last saw h... alive on Aug 27 1940

Immediate cause of death	DURATION
acute cardiac delatation	4 days.
Due to generalized arteriosclerosis	8 yrs.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Thomas E. Mattingly MD M. D. or other

Address 2200 R.I. Ave N.E. Date signed 8/31/40

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
SEP 5 1940
BUREAU F. S.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (170-C)

08762

CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH:

County Prince George

City or town Landover
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Landover Road.

Stay in hospital or inst. (yrs., or mos., or days) Transient

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Prince George

City or town Edmonston Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 5th and Sibley Ave
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Amy Isabelle Dearstine

3. (b) Social Security Number

4. Sex: Female

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Myron Charles Dearstine

6(c) If alive, give age 36 years

7. Birth date of deceased (mo., day, yr.) Dec 29, 1910

8. AGE: Years 29 | Months 7 | Days 26 | If less than one day ___ hrs. ___ min.

9. Birthplace McLean Va.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name Ferris Morgan
13. Birthplace Pennsylvania

MOTHER
14. Maiden name Clara Simpson
15. Birthplace Maryland

16. Informant Myron C Dearstine
Address Edmonston Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 29/1940 (month) (day) (year)

Cemetery or crematory Bladensburg Md Evergreen Cemetery

Location Bladensburg Md

18. Funeral director F. Gaeck's Sons
Address Hyattsville Md

19. Aug 26 1940 (Date rec'd by registrar) F Wm Norgle LOCAL Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 25 1940, at 12:30 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ___ 19___, to ___ 19___, and that I last saw h___ alive on ___ 19___.

Immediate cause of death: Hemorrhage Shock

Due to: Compound fracture of skull

Due to: Crushed chest

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

DURATION

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: accident Date of 8-25-40

Where did injury occur? Landover (City or town) Pr Geo (County) Md (State)

Injured at home, farm, industry, public place (where?) State Road

Means of injury Car turned over Injured at work? no

23. SIGNATURE James W Boyd M. D. or other

Address Forestville Md Date signed 8-25-40

RECEIVED
SEP 4 1940
BUREAU V. S.

MARGIN RESERVED FOR BINDING

VS A15 (T)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(M)

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (188)

08763

CERTIFICATE OF DEATH

Reg. Dist. No. 237

1. PLACE OF DEATH:

County Prince George

City or town Brandywine
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: White's Hill Farm

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) Life

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Prince George

City or town Brandywine Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. White's Hill Farm
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Margaret Jane Downing

3. (b) Social Security Number

4. Sex: Female

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 8, 1874

8. AGE: Years 66 | Months 2 | Days 2 | If less than one day hrs. min.

9. Birthplace Brandywine Md
(Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

FATHER
12. Name John Z Downing
13. Birthplace Maryland

MOTHER
14. Maiden name Elizabeth Richardson
15. Birthplace Maryland

16. Informant Cora Lee Downing
Address Brandywine Md

17. Burial (Burial, cremation, or removal, Which?) Date thereof Aug 12/40 (month) (day) (year)

Cemetery or ~~cremetery~~ Family Cemetery

Location Near Popular Hill, Pr. Geo., Co. Md.

18. Funeral director A. J. Grimes

Address Aquasco Maryland

19. Aug 12th 1940 (Date rec'd by registrar) Mrs Henry B. Coutee Dep. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 10 1940, at 5P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 , to 19 ,
and that I last saw h alive on 19 .

Immediate cause of death Pulmonary Embolism

Due to Compound fracture of left radius and

Due to Ulna

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy none

DURATION

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of 7-31-40

Where did injury occur? Brandywine (City or town) Prince (County) Md (State)

Injured at home, farm, industry, public place (where?) Farm

Means of injury Kicked by a cow Injured at work? yes

23. SIGNATURE James S. Boyd M. D. or other

Address Westville Md Date signed 8-10-40

RECEIVED
SEP 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08764

Reg. Dist. No. 243

1. PLACE OF DEATH:

County: Prince George

City or town: Glenn Dale

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 mos.

Hospital, institution, or street address where death occurred: Glenn Dale Sanatorium

How long in hospital or institution? 4 mos.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 402 - N st, N.W.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Alberta Earle

3.(b) Social Security Number: 579-14-7924

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Dec. 2, 1919

8. AGE: Years	Months	Days	If less than one day
20	8	6	hrs. min.

9. Birthplace: S. C. (Town, county, and state)

10. Usual occupation: Housework

11. Industry or business: home

FATHER

12. Name: James Earle

13. Birthplace: S. C.

MOTHER

14. Maiden name: Bertie Faut

15. Birthplace: S. C.

16. Informant: deceased

Address: -

17. Removal (Burial, cremation, or removal. Which?) Date thereof: Aug 8 1940 (month) (day) (year)

Cemetery or crematory:

Location: Washington D. C.

18. Funeral director: Thomas Frazier

Address: 389 - R I Ave N W

19. Aug 8 1940 (Date rec'd by registrar) Leo V. Almeida M.D Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 8 1940 at 4:10 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr. 9 1940 to Aug 8 1940 and that I last saw h.e alive on Aug 8 1940

Immediate cause of death	DURATION
Pulmonary Tuberculosis	4½ mos.
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: none

Date of op.:

Autopsy results: Pulmonary Tuberculosis.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D. M. D. or other

Address: Glenn Dale Sanatorium Date signed:

Glenn Dale md.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

RECEIVED
SEP 2 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

08765

CERTIFICATE OF DEATH

Reg. Dist. No. 235

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Prince George

City or town Oxon Hill, Anacostia D.C. (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Anacostia DC R#1

Stay in hospital or insi. (yrs., or mos., or days) —

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Md. County Pr. George Co.

City or town Oxon Hill, Md. Ward No. (If outside city or town limits, write RURAL NEAR and give town)

Street No. (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Naomi E. Fisher

3. (b) Social Security Number

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Fem	white	Widowed.

6 (b) Name of husband or wife John T. Fisher

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 11th 1860

8. AGE: Years	Months	Days	If less than one day
80	—	4	hrs. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name Benedict Edelen

13. Birthplace Maryland

MOTHER 14. Maiden name Joanna Middleton

15. Birthplace Maryland

16. Informant Adrian P. Fisher

Address Oxon Hill, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8-17-1940 (month) (day) (year)

Cemetery or crematory St. Barnabas

Location Oxon Hill, Md.

18. Funeral director Thos. F. Murray

Address 2007 - Nichols Ave S.E.

19. Aug 15 1940 (Date rec'd by registrar) L.O Minear Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 15 1940, at 6:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 29 1940, to Aug 15 1940, and that I last saw her alive on Aug 14 1940.

Immediate cause of death	DURATION
Cerebral Hemorrhage with Paralysis Left side of body	16 days
Due to General Arteriosclerosis	Unknown
Due to —	
Other conditions —	

(Include pregnancy within 3 months of death)

Major findings:

Of operations —

Of autopsy none

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: *

Accident, suicide, or homicide — Date of

Where did injury occur? — (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) —

Means of injury — Injured at work? —

23. SIGNATURE Paul C. VanMatta M.D.

M. D. or coroner

Address Bennings DC R#1 Date signed Aug 15 1940.

RECEIVED
SEP 6 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08766

Reg. Dist. No. 243

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Prince Georges
City or town: Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 9 months, 28 days
Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium
How long in hospital or institution? 9 months, 28 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D. C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 308 McLean Avenue, S.W. Wash. D.C.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Joseph Garner

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

6.(b) Name of husband or wife: None
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): October 29, 1906

8. AGE: Years	Months	Days	If less than one day
33	8	2	hrs. min.

9. Birthplace: Washington, D. C.
(Town, county, and state)
10. Usual occupation: Worked in a Pool Parlor
11. Industry or business
FATHER 12. Name: Frank Garner
13. Birthplace: Unknown
MOTHER 14. Maiden name: Maggie Guilder
15. Birthplace: Unknown
16. Informant: Deceased
Address: 308 McLean Ave. S.W. Wash. D.C.
17. Removal (Burial, cremation, or removal. Which?) Date thereof: Aug. 22, 1940 (month) (day) (year)
Cemetery or crematory:
Location: Washington, D.C.
18. Funeral director: Eugene Ford
Address: 1300 S. Capitol St.
19. Aug. 22 1940 (Date rec'd by registrar) L. V. Allred M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 22 1940, at 9:00 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 25 1939, to August 22 1940
and that I last saw h.l.m. alive on Aug. 22, 1940
Immediate cause of death: Pulmonary tuberculosis — DURATION: App. 4 yrs.
Due to: — 8 mos.
Due to: — 22 days
Other conditions: Bronchial Asthma — 5 years
(Include pregnancy within 3 months of death)
Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D.
M. D. or other
Address: Glenn Dale Sanatorium Date signed: 8/22/40
Glenn Dale, Md.

RECEIVED
SEP 3 1940
U. S.

08767

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH:

County: Prince George's County

City or town: Glenn Dale (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 month 14 days

Hospital, Institution, or street address where death occurred: Glenn Dale Sanatorium

How long in hospital or institution? 1 month 14 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: D. C. County:

City or town: WASHINGTON (If outside city or town limits, write RURAL and give nearest town)

Street No. 431 P St, N.W. (If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: DAVID GLENN

3. (b) Social Security Number: 577-05-8554

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	BLACK	WIDOWER

6.(b) Name of husband or wife: ERNESTINE GLENN

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): JUNE 27, 1904

8. AGE:

Years	Months	Days	If less than one day
36	1	20	..... hrs. ..... min.

8. Birthplace: SOUTH CAROLINA (Town, county, and state)

10. Usual occupation: PRESSER

11. Industry or business: PRESSING AND CLEANING

FATHER
12. Name: GEORGE GLENN
13. Birthplace: SOUTH CAROLINA

MOTHER
14. Maiden name: CORRIE GILLIAM
15. Birthplace: SOUTH CAROLINA

16. Informant: deceased.

Address:

17. Removal (Burial, cremation, or removal. Which?) Date thereof: 8/17/40 (month) (day) (year)

Cemetery or crematory: —

Location: Washington, D.C.

18. Funeral director: George Clarke

Address: 1416 Florida Ave., N.E., Wash. D.C.

19. 8-17 1940 (Date rec'd by registrar) Leo V. Schneider M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 17 1940, at 3:30 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 3 1940, to August 17 1940 and that I last saw him alive on August 17 1940

Immediate cause of death: Pulmonary Tuberculosis

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

DURATION: FIVE MONTHS

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D. M. D. or other

Address: Glenn Dale Sanatorium Date signed: 8/17/40

Glenn Dale Md.

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
SEP 2 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-B)

CERTIFICATE OF DEATH

08768

Reg. Dist. No. 239

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Prince Georges
City or town Laurel WITHIN CORPORATE LIMITS
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days) No
Stay in this community (yrs., or mos., or days) 17 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Prince George
City or town Laurel Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 204 Laurel Ave
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR —

3. (a) FULL NAME Annie Colborn Gough

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife Richard Gough deceased 6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 8, 1866

8. AGE: Years	Months	Days	If less than one day
74 years	4	29	hrs. min.

9. Birthplace Charlotte Hall St Marys County
(Town, county, and st...)
10. Usual occupation Housewife
11. Industry or business No.
FATHER 12. Name Lewis J. Patterson
13. Birthplace St Marys County
MOTHER 14. Maiden name Lydia A Coulter
15. Birthplace St Marys County
16. Informant Henry Gough (Son)
Address Laurel Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 8, 1940 (month) (day) (year)
Cemetery or crematory Cemetery Md.
Location Trinity Church - Charles County
18. Funeral director Chas A Dorsey
Address Laurel Md.
19. Aug 8 1940 (Date rec'd by registrar) W. Brashears Registrar Local

MEDICAL CERTIFICATION

20. DATE OF DEATH August 6 1940, at 10:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1937, to Aug 6 1940, and that I last saw h-- alive on Aug 6 1940.

Immediate cause of death Cancer of stomach (46) — DURATION 2 mo.

Due to — DURATION

Due to — DURATION

Other conditions — DURATION

(Include pregnancy within 3 months of death)

Major findings:
Of operations None
Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide None Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Robert S McCamey MD
M. D. or other
Address Laurel Md Date signed 8/7/40

RECEIVED
SEP 3 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08769

243

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Prince Georges Md
City or town: Glenn Dale Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 mos. 20 days
Hospital, Institution, or street address where death occurred:
Glenn Dale Sanatorium
How long in hospital or institution? 3 mos. 20 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D.C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1103 - 5th ST. N.W.
(If rural, give LOCATION)
2.(a) If veteran, name war: —

3.(a) FULL NAME Paul Green

3.(b) Social Security Number 578-14-1341

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

6.(b) Name of husband or wife: Single
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 19, 1909

8. AGE: Years	Months	Days	If less than one day
31	3	1	hrs. min.

9. Birthplace: St Marys Co. Maryland
(Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business
FATHER 12. Name: Jas. Greene
13. Birthplace: St. Marys Co. Md.
MOTHER 14. Maiden name: Tilley Courtney
15. Birthplace: St Marys Co. Md.
16. Informant: Deceased
Address: 1103 - 5th St. N.W. Wash. D.C.
17. Removal (Burial, cremation, or removal. Which?) Date thereof: Aug. 20, 1940 (month) (day) (year)
Cemetery or crematory:
Location: Washington, D.C.
18. Funeral director: Sonnie W. Brown
Address: 1344 - 4th Street, N.W. Washington, D.C.
19. Aug 20 1940 (Date rec'd by registrar) L. V. McWade M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 20th 1940, at 8:45 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 25th 1940, to Aug. 20th 1940 and that I last saw him alive on Aug. 20th 1940

Immediate cause of death	DURATION
Pulmonary Tuberculosis	9 mos.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results: Pulmonary Tuberculosis
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D.
M. D. or other
Address: Glenn Dale Sanatorium Date signed: 8/20/40
Glenn Dale, Md.

RECEIVED
SEP 2 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (13)

Reg. Dist. No. 242

08770

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

(a) County Prince Geo County

(b) City or town East Riverdale Md (If outside city or town limits, write RURAL and give town)

(c) Street address, hospital, or institution: Beacon Light Rd.

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in this community (yrs., mos., or days)

2. HOME (USUAL RESIDENCE) OF DECEASED:

(a) State (b) County

(c) City or town (If outside city or town limits, write RURAL and give town)

(d) Street No. 1713-8th St. N.W. D.C (If rural give location)

(e) If foreign born, how long in U. S. A.? years ✓

3 (a) FULL NAME George W. Grice

3 (b) If veteran, name war

3 (c) Social Security No.

4. Sex m

5. Color or race col.

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Constance Grice

6. (c) If alive, give age 42 years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 40 | Months | Days | If less than one day ____ hr. ____ min.

9. Birthplace Wash. D.C. (Town, county, and state)

10. Usual occupation Mortician

11. Industry or business

FATHER

12. Name Geo. W. Grice

13. Birthplace Wash. D.C.

MOTHER

14. Maiden Name Mary L. Swann

15. Birthplace Charles County Md

16 (a) Informant Hillary Brown 1713-8 St. N.W.

(b) Address Wash. D.C.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-10-40 (month) (day) (year)

(c) Cemetery or crematory Harmony

Location R. I. ave N.W. bet 8 & 9

18 (a) Funeral director John T. Stewart

(b) Address 30-H St. N.E.

19 (a) 8-8-1940 (Date rec'd by registrar) (b) Irene A. Conner Registrar

MEDICAL CERTIFICATION

20. Date of death 8-8 1940, at 12:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from April 2 1940, to Aug 8 1940, and that I last saw him alive on Aug 7, 1940.

Immediate cause of death Tubercular Peritis

Due to Pulmonary Tuberculosis

Due to —

Other conditions —

(Include pregnancy within 3 months of death)

Major findings:

Of operations —

Of autopsy —

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide —

(b) Date of occurrence —

(c) Where did injury occur? — (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? — (Specify type of place) While at work? —

(e) Means of injury

23. Signature Le Count R. Mortimer M. D. or other

Address 1735 First St NW Date signed 8.8.40

VS. A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
SEP 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (58)

CERTIFICATE OF DEATH

08771

Reg. Dist. No. 230

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Prince Georges

City or town Berwyn

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince Georges

City or town Berwyn Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Helen Elizabeth Guest

3. (b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	married

6 (b) Name of husband ~~or wife~~ John F. Guest

6(c) If alive, give age 44 years

7. Birth date of deceased (mo., day, yr.) Aug. 27, 1897

8. AGE: Years 42 | Months 11 | Days 23 | If less than one day ____ hrs. ____ min.

9. Birthplace D. C.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Own Home

FATHER 12. Name Harry E. Clarkson

13. Birthplace Junk.

MOTHER 14. Maidee name Clara E. Perkins

15. Birthplace Junk

16. Informant John F. Guest

Address Berwyn, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 23 1940 (month) (day) (year)

Cemetery or crematory Fort Lincoln

Location Bladensburg, Prince Geo Co. Md.

19. Funeral director W. W. Chambers Co.

Address Riverdale Md.

19. Aug. 21, 1940 (Date rec'd by registrar) John D. Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 20 1940., at 10 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 13 1940, to Aug 20 1940, and that I last saw h ~~e~~ alive on Aug 20 1940.

Immediate cause of death	DURATION
Acute Coronary Thrombosis	
Due to Carcinoma of breast.	
Due to	
Other conditions Metastatic Ca.	

(Include pregnancy within 3 months of death)

Major findings: Of operations Amputation of breast July 1939 - Ca & metastasis

Of autopsy

PHYSICIAN Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Martin Pierce M. D. or other

Address Riverdale Md Date signed 8/20/40.

RECEIVED
SEP 4 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08772

Reg. Dist. No. 245

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Prince George's

City or town: Rural Near Hyattsville, Md.
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Mother Jones Rest Home
Agen Road, Hyattsville, Md.

Stay in hospital or inst. (yrs., or mos., or days): 2 months 26 days

Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: County:

City or town: Baltimore Md Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 2796 Alameda
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME Louis Phillip Gundlach

LOUIS PHILLIP GUNDLACH

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	WIDOWER

6 (b) Name of husband or wife: ELIZABETH

DECEASED 6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): NOV. 13, 1861

8. AGE: Years 78 | Months 8 | Days 21 | If less than one day: hrs. min.

9. Birthplace: BALTIMORE, MD.
(Town, county, and state)

10. Usual occupation: MERCHANT

11. Industry or business: SHOE

FATHER 12. Name: GEORGE

FATHER 13. Birthplace: GERMANY

MOTHER 14. Maiden name: KATHERINE TRUSS

MOTHER 15. Birthplace: GERMANY

16. Informant: Mother Jones Rest Home

Address: Riggs Road Near Hyattsville Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug. 6 1940
(month) (day) (year)

Cemetery or crematory: London Park

Location: Baltimore Md

16. Funeral director: Hedgerick & Cole

Address: 1200 W Lombard St

19. Aug 3 1940 (Date rec'd by registrar) Jas Devey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 3 1940; at 7:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1 1940 to Aug 3 1940, and that I last saw h[im] alive on Aug 3 1940.

Immediate cause of death: Acute Coronary Occlusion — DURATION: 8/3/40

Due to: Chr. Myocarditis — Duration:

Due to: Primary Cancer of Sigmoid — Duration:

Other conditions: Cancer Cervix — Duration:

Jaundice — Duration:
(Includa pregnancy within 3 months of death)

Major findings: not stated

Of operations: None

Of autopsy:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE. If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Myerly Lowe M. D. or other

Address: Cumberland Md Date signed: 8/3/40

RECEIVED
AUG 14 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

08773

CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH:

County: Prince George

City or town: College Park, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Prince George

City or town: College Park
(If outside city or town limits, write RURAL and give nearest town)

Street No.: West Wellesley Avenue
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Blanche Waters Hall

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Frederick A. Hall

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): June 26, 1864

8. AGE:

Years	Months	Days	If less than one day
76	2	8	..... hrs. ..... min.

9. Birthplace: Washington, D. C.
(Town, county, and state)

10. Usual occupation: At home

11. Industry or business

FATHER
12. Name: Robert A. Waters
13. Birthplace: Washington, D. C.

MOTHER
14. Maiden name: Ann M. Mickum
15. Birthplace: Georgetown, D. C.

16. Informant: Blanche S. Lyddane

Address: 3068 Que St., N.W., Washington, D.C.

17. Yes (Burial, cremation, or removal. Which?) Date thereof: Aug. 24, 1940 (month) (day) (year)

Cemetery or crematory: Glenwood Cemetery

Location: Washington, D. C.

18. Funeral director: Jos. Gawlers Son

Address: 1756 Pa. Ave., N.W., Washington, D.C.

19. Aug. 23, 1940 (Date rec'd by registrar) Mrs. Jas. Severe Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug - 22 - 1940, at 4:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan - 2 - 1938, to Aug - 22 1940 and that I last saw her alive on Aug - 21 - 1940

Immediate cause of death: Arteriosclerotic Heart Disease — DURATION: 6 months

Due to

Due to

Other conditions: Chronic Arthritis — 2-1/2 yrs.

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work?

23. SIGNATURE: E. Kim Gyadore M.D. (M. D. or other)

Address: 3066 Que St. Date signed: Aug 22 1940

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
SEP 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-b)

08774

CERTIFICATE OF DEATH

Reg. Dist. No. 236

1. PLACE OF DEATH:

County: Prince Geo

City or town: Hall Md
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days): 10 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Prince Geo

City or town: Halls Md Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Henry Lee Hamilton Sr.

3. (b) Social Security Number

4. Sex: Male

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Susannah Hamilton

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): Feb 6 1864

8. AGE: Years: 76 Months: 5 Days: 27 If less than one day ____ hrs. ____ min.

9. Birthplace: Prince Georges Co Md
(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business: Farming

FATHER
12. Name: Benjamin Hamilton
13. Birthplace: Prince Georges Md

MOTHER
14. Maiden name: Mary Elizabeth Watson
15. Birthplace: Pr. Geo. County, Md

16. Informant: Maud H. Ogle
Address: Upper Marlboro Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug. 5-40. (month) (day) (year)

Cemetery or crematory: St. Thomas Episcopal.

Location: Croom, Md.

18. Funeral director: Ritchie Brothers

Address: Upper Marlboro, Md.

19. Aug. 3 1940 (Date rec'd by registrar) Effie B. Pumphrey Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 3 1940, at 4-3 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1 1940, to Aug 3 1940, and that I last saw him alive on Aug 1 1940.

Immediate cause of death: Angina Pectoris — DURATION: 1 month
Chronic Nephritis — 2 yrs

Due to

Due to

Other conditions: Chronic Myocarditis — 1 yr
(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy: no

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ____ Date of ____

Where did injury occur? ____ (City or town) ____ (County) ____ (State)

Injured at home, farm, industry, public place (where?)

Means of injury ____ Injured at work?

23. SIGNATURE: Reverdy Sasscer
M. D. or other

Address: Upper Marlboro Md Date signed: 8/3/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
AUG 6 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08775

Reg. Dist. No. 243

1. PLACE OF DEATH:

County: Prince George

City or town: Glenn Dale

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 mos. 19 da.

Hospital, Institution, or street address where death occurred:

Glenn Dale Sanatorium

How long in hospital or institution? 3 mos. 19 da.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 813 - 3rd st., S.W.

(If rural, give LOCATION)

2.(a) If veteran, name war: —

3.(a) FULL NAME: William James Hawkins

3.(b) Social Security Number: 577-22-2706

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	single

6.(b) Name of husband or wife: —

6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): Oct. 24, 1918

8. AGE: Years	Months	Days	If less than one day
21	9	26	...hrs. ...min.

9. Birthplace: Washington D. C.

(Town, county, and state)

10. Usual occupation: Chef

11. Industry or business: cafeteria

FATHER 12. Name: Ernest James Hawkins

13. Birthplace: St. Mary's Co, Md.

MOTHER 14. Maiden name: Lottie Green

15. Birthplace: St. Mary's Co, Md.

16. Informant: deceased

Address: —

17. Removal (Burial, cremation, or removal. Which?) Date thereof Aug. 20, 1940 (month) (day) (year)

Cemetery or crematory:

Location: Washington, D.C.

18. Funeral director: Theodore Mathews

Address 614 - 4½ Street S.W.

19. Aug 20 1940 (Date rec'd by registrar) Leo V. Allwein M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 20 1940, at 3 35 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1 1940, to Aug 20 1940

and that I last saw h.i.m. alive on Aug 20 1940

Immediate cause of death

	DURATION
Pulmonary Tuberculosis	6 mo.
Acute Miliary Tuberculosis	2 mo.
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results: Pulmonary and Miliary Tuberculosis

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Daniel Lee Finucan M.D. M. D. or other

Address: Glenn Dale Sanatorium Date signed: 8/20/40

Glenn Dale md.

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
SEP 3 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Stillbirth

Reg. Dist. No. 235

08776

1. PLACE OF DEATH:
County ~~Charles County~~ Prince Geo, Md.
City or town Forte Foote Md.
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: —
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 2 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State County
City or town Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Baby Heinbuch

3. (b) Social Security Number

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
m	w	—

6 (b) Name of husband or wife
6(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Aug. 12th 1940

8. AGE: Years — Months — Days — If less than one day hrs. min.

8. Birthplace Prince George Co
(Town, county, and state)
10. Usual occupation —
11. Industry or business
FATHER 12. Name Alton Heinbuch
13. Birthplace Va
MOTHER 14. Maiden name Dorothy Johnson
15. Birthplace Washington D.C.
16. Informant Mrs Dorothy Johnson
Address Prince Geo Co Md.
17. Removal (Burial, cremation, or removal. Which?) Date thereof 8-12-40 (month) (day) (year)
Cemetery or crematory
Location Washington, D.C.
18. Funeral director W. W. Chambers Co.
Address 517 11th St S.E.
19. 8/12 1940 (Date rec'd by registrar) L. O. Minear Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/12 1940, at 6:00 AM
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from — 19 —, to — 19 —,
and that I last saw him ~~alive on~~ 8/12 1940.

Immediate cause of death Stillbirth
Due to Premature Separation of Placenta
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings:
Of operations none
Of autopsy none

DURATION

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE C W Johnson MD Samuel Zorn MD
M. D. or other
Address 2904 Nichols Ave SE Date signed 8/17/40

VS A15 MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
SEP 6 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (161-E)

08777

CERTIFICATE OF DEATH

Reg. Dist. No. 240

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Prince Georges

City or town: Greenbelt

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Greenbelt Hosp.

Stay in hospital or inst. (yrs., or mos., or days): 3 days

Stay in this community (yrs., or mos., or days): 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Pr. Georges

City or town: Greenbelt Md Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Wells F. Honeycutt Jr.

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	S

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): 8/9/40

8. AGE:

Years	Months	Days	If less than one day
0	0	3	hrs. min.

9. Birthplace: Greenbelt (Pr. Georges) Md

(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name: Wells F. Honeycutt

13. Birthplace: Ark.

MOTHER

14. Maiden name: Martha K. Embley

15. Birthplace: Ark.

16. Informant: Martha K. Embley

Address: Greenbelt, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8/15/40 (month) (day) (year)

Cemetery or crematory: Greenbelt

Location: Greenbelt, Md.,

18. Funeral director: Harvey Vincent

Address: Greenbelt, Md.

19. Aug. 14th 1940 (Date rec'd by registrar) John D Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 8/12/40 19 , at 4:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8-9- 19 40, to 8-12 19 40, and that I last saw h- alive on 8-12- 19 40.

Immediate cause of death	DURATION
Erythroblastosis Fetalis	
Due to Congenital	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Jos W Stiles M.D.

M. D. or other

Address: Greenbelt Md Date signed 8/13/40

RECEIVED
SEP 4 1940
BUREAU V. S.

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08778

Reg. Diat. No. 243

1. PLACE OF DEATH:
County: Prince George
City or town: Glenn Dale
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 mos. 18 da
Hospital, Institution, or street address where death occurred: Glenn dale Sanatarium
How long in hospital or institution? 4 mos. 18 da.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: District of Columbia County:
City or town: Melenstan
(If outside city or town limits, write RURAL and give nearest town)
Street No. 148 U st. n.w.
(If rural, give LOCATION)
2.(a) If veteran, name war: —

3. (a) FULL NAME: Marion C. Jackson

3. (b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Fem.	Col	Widowed

6.(b) Name of husband or wife: James Jackson (Deceased) 6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): June 11, 1912

8. AGE: Years: 28 | Months: 2 | Days: 7 | If less than one day: ____ hrs. ____ min.

9. Birthplace: Prince William County, Va.
(Town, county, and state)

10. Usual occupation: Ward attendant

11. Industry or business: Hospital

FATHER
12. Name: John Russell
13. Birthplace: Virginia

MOTHER
14. Maiden name: Marie Bumbrey
15. Birthplace: Virginia

16. Informant: husband
Address: above

17. (Burial, cremation, or removal. Which?) Removal to Date thereof Aug. 18, 1940 (month) (day) (year)

Cemetery or crematory:
Location: Washington, D.C.

18. Funeral director: George A. Bitter Sons
Address: 1208 Walter St. S.E.

19. Aug 18 1940 (Date rec'd by registrar) Leo V. Kilmede M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 18 1940, at 5:30a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 30 1940 to Aug. 18 1940 and that I last saw h.er alive on Aug. 18 1940

Immediate cause of death: Pulmonary Tuberculosis — DURATION: about 8 mos.

Due to: —

Due to: —

Other conditions: —

(Include pregnancy within 3 months of death)

Major findings of operations: —
Date of op.: —

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Daniel Lee Finucane M.D. (M. D. or other)
Address: Glenn Dale Sanitorium Date signed: 8-18-40
Glenn Dale md

RECEIVED
SEP 2 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore (50)

CERTIFICATE OF DEATH

08779

Reg. Dist. No. 235

1. PLACE OF DEATH:
County Pr Geo
City or town Temple Hills
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 1 week

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Pr. Geo.
City or town Temple Hills Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Caroline A Johnson

3. (b) Social Security Number

4. Sex: Fem
5. Color or race: White
6. (a) Single, married, widowed, or divorced: Widowed.
6 (b) Name of husband or wife
6(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Oct 16 - 1889

8. AGE: Years 50 ~~44~~? Months 9 Days 27 If less than one day hrs. min.

9. Birthplace Springfield, Ill. (Town, county, and state)
10. Usual occupation Federal employee
11. Industry or business Stenographer & typist
FATHER 12. Name William C. Garrard
13. Birthplace Maysfield Ky
MOTHER 14. Maiden name Caroline?
15. Birthplace Springfield, Ill
16. Informant Louis Woulf.
Address Gardan Hotel Ill.
17. Arlington (Burial, cremation, or removal, Which?) Date thereof Aug 15-40 (month) (day) (year)
Cemetery or crematory Arlington National
Location Va.
18. Funeral director Jos. Gawler
Address 1756 Pa. Ave N.W.
19. 8-12 1940 (Date rec'd by registrar) L.O. Minear Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 12 1940, at 11 45 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 10 1940, to Aug 12 1940 and that I last saw her alive on Aug 12 1940
Immediate cause of death Pulmonary Edema — DURATION 24 hours
Due to Metastatic Carcinoma of Lung. — 6 mo.
Due to Carcinoma of Left Breast — 1 year
Other conditions
(Include pregnancy within 3 months of death)
Major findings:
Of operations —
Of autopsy none

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: ~~200~~
Accident, suicide, or homicide — Date of —
Where did injury occur? — (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) —
Means of injury — Injured at work? —

23. SIGNATURE Paul C Van Natta M. D. or other
Address Bennings D.C. N #1 Date signed Aug 13, 1940.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
SEP 6 1940
BUREAU V. S.

08780

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (50)

CERTIFICATE OF DEATH

Reg. Dist. No. 239

1. PLACE OF DEATH:

County Prince Geo

City or town Laurel Md (WITHIN CORPORATE LIMITS OF)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 22 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince George

City or town Laurel Md

(If outside city or town limits, write RURAL and give nearest town)

Street No. 158 Lafayette Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Elizabeth A. Jones

3. (b) Social Security Number

4. Sex F

5. Color or race W

6.(a) Single, married, widowed, or divorced Widow

6.(b) Name of husband or wife James M. Jones

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Sept 20th 1848

8. AGE: Years 91 Months 11 Days 24 If less than one day ..... hrs. ..... min.

9. Birthplace Washington D.C. (Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name John M. Holbrook

13. Birthplace Wash. D.C.

MOTHER 14. Maiden name Susan L. LaGradlan

15. Birthplace Wash. D.C.

16. Informant Miss Virginia Jones

Address Laurel Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 28-40 (month) (day) (year)

Cemetery or crematory Congressional Cem.

Location Washington, D.C.

18. Funeral director L. Lloyd Kaiser

Address Laurel Md.

19. August 27 1940 (Date rec'd by registrar) Corle E. Wachter Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/24 1940, at 11.49 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jun 4 1939, to 8/24 1940 and that I last saw her alive on 8/24 1940

Immediate cause of death Carcinoma Breast — DURATION 1 yr +

Due to —

Due to —

Other conditions —

(Include pregnancy within 3 months of death)

Major findings of operations none

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE N B Pierce M. D. or other

Address Laurel Md Date signed 8/21/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
SEP 3 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore (46-E)

CERTIFICATE OF DEATH

08781

Reg. Dist. No. 245

1. PLACE OF DEATH

County: Prince George
City or town: Hyattsville (Near)
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Sacred Heart Home
Stay in hospital or inst. (yrs., or mos., or days): 2 mo.
Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D.C. County:
City or town: Washington Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 11-4 St. N.E.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Mary J. Kellerman

3. (b) Social Security Number:

4. Sex: female
5. Color or race: White
6. (a) Single, married, widowed, or divorced: Widowed
6(b) Name of husband ~~or wife~~: John Kellerman
6(c) If alive, give age ____ years
7. Birth date of deceased (mo., day, yr.): March 13, 1870
8. AGE: Years 70 | Months 4 | Days 22 | If less than one day ____ hrs. ____ min.
9. Birthplace: Washington D.C. (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business:
FATHER 12. Name: Malachi Gately
13. Birthplace: Ireland
MOTHER 14. Maiden name: Mary Flynn
15. Birthplace: Ireland
16. Informant: Sister Superior Sacred Heart
Address: Home
17. Burial (Burial, ~~cremation~~, or removal (Which?)) Date thereof: 8-7-40 (month) (day) (year)
Cemetery or crematory: Mt. Olivet Cemetery
Location: Bladensburg Road N.W.
18. Funeral director: Warner E. Pumphrey
Address: Silver Spring Md.
19. Aug. 5 1940 (Date rec'd by registrar) Mrs. Jas. Severe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 5 1940, at 5:45 M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 5 1940, to Aug. 5 1940, and that I last saw her alive on Aug. 4 1940.
Immediate cause of death: Intestinal obstruction (complete)
Due to: Probably Carcinoma small bowel.
Due to:
Other conditions: cardio vascular disease
(Include pregnancy within 3 months of death)
Major findings:
Of operations:
Of autopsy:

DURATION: 10 days; 3 years

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Thomas E. Mattingly M.D. M. D. or other
Address: 2200 R Ave. N.E. D.C. Date signed: 8/5/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
SEP 5 1940
BUREAU V. S.

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(170-C)

08782

CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH:

County Prince Georges

City or town Bladensburg

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Route #1

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) Transient

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State North Carolina County

City or town Charlotte Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. Piedmont Hotel

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Leonard H. Kerns

3. (b) Social Security Number 263-12-4427

4. Sex Male

5. Color or race White

6. (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 19, 1919

8. AGE: Years 21 Months 7 Days 11 If less than one day hrs. min.

9. Birthplace unk. (Town, county, and state)

10. Usual occupation Truck Driver

11. Industry or business Hauling

FATHER 12. Name unknown

13. Birthplace

MOTHER 14. Maiden name unknown

15. Birthplace

16. Informant unknown

Address

17. Removal (Burial, cremation, or removal, Which?) Date thereof 8-31-40 (month) (day) (year)

Cemetery or crematory McEwen Funeral Home

Location Matthews, Mecklenburg Co., N.C.

18. Funeral director F. Gasch's Sons.

Address Hyattsville, Md.

19. Aug 31 1940 (Date rec'd by registrar) F. Wm. Norgle Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 30 1940, at 11 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 , to 19 , and that I last saw h alive on 19

Immediate cause of death Shock

DURATION

Due to Universal third and fourth degree burns of body.

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

DI operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide accident Date of 8-30-40

Where did injury occur? Bladensburg (City or town) Prgs (County) Md (State)

Injured at home, farm, industry, public place (where?) State Road

Means of injury auto collided and caught on fire Injured at work? Yes

23. SIGNATURE James H. Boyd M. D. or other

Address Forestville Md Date signed 8-31-40

RECEIVED
SEP 4 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

08783

CERTIFICATE OF DEATH

Reg. Dist. No. 2 3 5

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Prince Georges
City or town Clinton, Md
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or Institution:
Stay in hospital or Inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 45 Years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Prince Georges
City or town Clinton Md Ward No.
(If outside city or town limits, write RURAL NEAR and give town) Anacostia R4
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Melvin Eugene Kerrick

3. (b) Social Security Number

4. Sex: Male
5. Color or race: Colored
6. (a) Single, married, widowed, or divorced: married.
6 (b) Name of husband or wife: Henrietta B Kerrick
6(c) If alive, give age 64 years
7. Birth date of deceased (mo., day, yr.): June 6 - 1873
8. AGE: Years 67 | Months 2 | Days 14 | If less than one day ____ hrs. ____ min.
9. Birthplace T. B - Md (Town, county, and state)
10. Usual occupation Farmer & Laborer
11. Industry or business General work & Farming

FATHER
12. Name Julien Kerrick
13. Birthplace T. B. Md

MOTHER
14. Maiden name Elmira Pinkney
15. Birthplace T. B. Md

16. Informant Henrietta B. Kerrick
Address Anacostia, D.C. R #4

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 23 1940 (month) (day) (year)
Cemetery or crematory T. B. Md.
Location

18. Funeral director Arthur L. Rollins
Address 4339 Hunt Pl. N.E. - D.C.

19. Aug 20 1940 (Date rec'd by registrar) L O Minear Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 20th 1940 2 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec August 20 1940, to ____ 19__ and that I last saw him alive on August 20 1940.

Immediate cause of death	DURATION
Cerebral Hemorrhage	10 hrs
Due to Arteriosclerosis	2 Years
Due to High Blood Pressure	several years
Other conditions Ulcer of stomach	2 yrs

(Include pregnancy within 3 months of death)

Major findings:
Of operations none
Of autopsy none

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide — Date of —
Where did injury occur? — (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work? —

23. SIGNATURE John E. Bowers M.D.
M. D. or other
Address Brandywine, Md Date signed Aug 20/40

RECEIVED
SEP 6 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-E)

08784

CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH:

County: Prince George

City or town: Hyattsville
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Sacred Heart Home

Stay in hospital or inst. (yrs., or mos., or days): 9 mo.

Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Wash. County: DC

City or town: Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: 2506 Eye N.W.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: No

3. (a) FULL NAME: Mrs Ella Komnerow

3. (b) Social Security Number:

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
female	white	widowed

6(b) Name of husband or wife: Peter Komnerow

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): August 1860

8. AGE: Years: 80 | Months: | Days: | If less than one day: ____ hrs. ____ min.

9. Birthplace: Washington D.C.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER
12. Name: Edward Garvey
13. Birthplace: Ireland

MOTHER
14. Maiden name: Annie Grealish
15. Birthplace: Ireland

16. Informant: Mrs. Mary R Fowler
Address: Seat Pleasant Md

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof: Aug. 29-1940 (month) (day) (year)

Cemetery or crematory: Cedar Hill Cemetery

Location: Prince Geo. Co. Md.

18. Funeral director: W. W. Chambers Co.

Address: 517 11th St S.E. Wash. DC

19. Aug 26th 1940 Mrs. Jas. Severe
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 26 1940, at 1:30 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 15 1940, to Aug. 26 1940, and that I last saw her alive on Aug 14. 1940.

Immediate cause of death: Arteriosclerosis — DURATION: 5 yrs.

Due to: Intestinal obstruction was very probably due to cancer — malignancy in sigmoid.

Due to: Duration: six months. C.W.G.R.

Other conditions: more forms of Intestinal obstruction; due to cancer. — 1 Mo.
(Include pregnancy within 3 months of death)

Major findings:
Of operations: None
Of autopsy: None

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ____ Date of ____

Where did injury occur? ____ (City or town) ____ (County) ____ (State)

Injured at home, farm, industry, public place (where?) ____

Means of injury ____ Injured at work? ____

23. SIGNATURE: Thomas E Mattingly MD
M. D. or other

Address: 2200 R Ave NE DC Date signed: 8/26/40

VS A15 (T) (1)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
SEP 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-2)

08785

CERTIFICATE OF DEATH

Reg. Dist. No. 245

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Prince Georges

City or town: East Riverdale

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 1201 - Edmonston Rd.

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days): 5 years

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Prince Georges

City or town: East Riverdale Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. 1201 - Edmonston Rd

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Smith Lee

3. (b) Social Security Number: None

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife: Annie Lee

6(c) If alive, give age: 60 years

7. Birth date of deceased (mo., day, yr.): May 23, 1888

8. AGE: Years: 52 | Months: 3 | Days: 2 | If less than one day: 0 hrs. 29 min.

9. Birthplace: Aurora, N. C. (Town, county, and state)

10. Usual occupation: Clerk

11. Industry or business: Post Office

FATHER 12. Name: George Washington Lee

FATHER 13. Birthplace: Aurora N.C.

MOTHER 14. Maiden name: Winnifred Holmes

MOTHER 15. Birthplace: N.C.

18. Informant: Mrs Annie Lee

Address: 1201 Edmonston Rd Rivedale Md

17. Transportation (Burial, cremation, or removal. Which?) Date thereof: Aug. 23, 1940 (month) (day) (year)

Cemetery or crematory:

Location: Greenville, North Carolina

18. Funeral director: W. W. Chambers Company

Address: Riverdale, Md.

19. Aug 23 1940 (Date rec'd by registrar) Mrs Jas Devere Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 22 19 40, at 5:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ____ 19____, to ____ 19____, and that I last saw h____ alive on ____ 19____.

Immediate cause of death	DURATION
Acute Congestive heart failure	
Due to Myocardosis	
Due to Myocardosis - Duration - indefinite	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ____ Date of ____

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ____ Injured at work?

23. SIGNATURE: James D. Bond M. D. or other

Address: Forestville Md Date signed 8-27-40

RECEIVED
AUG 29 1940
BUREAU V. 6

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-A)

CERTIFICATE OF DEATH

08786

Reg. Dist. No. 230

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Prince Georges

City or town Berwyn Heights

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 21 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince Geo

City or town Berwyn Heights Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Rosalie E. McDonald

3. (b) Social Security Number None.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	Single

6 (b) Name of husband or wife —

6(c) If ellve, give age years

7. Birth date of deceased (mo., day, yr.) unknown

8. AGE: Years	Months	Days	If less than one day
68 ?			hrs. min.

9. Birthplace Baltimore Md.

(Town, county, and state)

10. Usual occupation Retired clerk

11. Industry or business Wash. Term. Co.

FATHER 12. Name John McDonald

13. Birthplace Scotland

MOTHER 14. Maiden name Katherine L. Fitzgerald

15. Birthplace Ireland

16. Informant Anna Harlup

Address 908 Eye St. N.W.

17. Burial Date thereof Aug. 17, 1940

(Burial, cremation, or removal. Which?) (Month) (day) (year)

Cemetery or crematory Mt. Olivet

Location Washington, D.C.

18. Funeral director W. W. Chambers Co.

Address Riverdale Md.

19. Aug. 12 1940 John D. Smith

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 12 1940, at 6 3/4 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1938 19 , to August 12 1940, and that I last saw her alive on August 11 1940.

Immediate cause of death Chronic Myocarditis — DURATION 2 years

Due to —

Due to —

Other conditions Senility — 2 years

(Include pregnancy within 3 months of death)

Major findings: —

Of operations —

Of autopsy —

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —

Where did injury occur? — — —

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) —

Means of injury — Injured at work? —

23. SIGNATURE W. Allen Griffith M. D. or other

Address Berwyn, Md. Date signed Aug 12 1940

RECEIVED
SEP 4 1963
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (136)

CERTIFICATE OF DEATH

08787

Reg. Dist. No. 243

VS A15 (T)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
County: Prince Georges
City or town: Glenn Dale md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 mos
Hospital, institution, or street address where death occurred: Glenn Dale Sanatorium
How long in hospital or institution? 10 mos

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D.C. County: —
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1529 North Carolina Ave N.E.
(If rural, give LOCATION)
2.(a) If veteran, name war: no

3.(a) FULL NAME: Joseph Warren Medley

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

6.(b) Name of husband or wife: Single
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Sept 6th, 1920

8. AGE: Years	Months	Days	If less than one day
19	11	0	..... hrs. ..... min.

9. Birthplace: Wash DC
(Town, county, and state)
10. Usual occupation: Student
11. Industry or business

FATHER
12. Name: Benjamin Medley
13. Birthplace: Md

MOTHER
14. Maiden name: Florence Littleton
15. Birthplace: Virginia

18. Informant: Deceased
Address: 1529 N.C. Ave N.E. Wash DC

Removal to
(Burial, cremation, or removal. Which?)
Date thereof: Aug 7, 1940
(month) (day) (year)

Cemetery or crematory
Location: Washington D.C.

18. Funeral director: John J. Phinn
Address: 901 3 St S.W.

19. Aug 7 1940 (Date rec'd by registrar) Lee V. Schneider M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 6th 1940, at 8:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 20th 1939 to Aug 6th 1940 and that I last saw him alive on Aug 6th 1940

Immediate cause of death	DURATION
Pulmonary Tuberculosis	14 yr 8 mos
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: Pulmonary Tuberculosis.
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Daniel Leo Duncan M.D.
M. D. or other
Address: Glenn Dale Sanatorium Date signed .....
Glenn Dale, Md.

RECEIVED
SEP 2 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (31a)

CERTIFICATE OF DEATH

08788

Reg. Dist. No. 232

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Prince Georges

City or town Meadows

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 20 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince Georges

City or town Meadows Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) IF YETERAN, NAME WAR

3. (a) FULL NAME Charles Lawrence Mitchell

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 12, 1877.

8. AGE:

Years	Months	Days	If less than one day
63	6	22	hrs. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual occupation Retired

11. Industry or business

FATHER

12. Name James Henry Enslow Mitchell

13. Birthplace Maryland

MOTHER

14. Maiden name Mary Muddiman

15. Birthplace District of Columbia

16. Informant John M. Taylor

Address Meadows, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug. 6-40. (month) (day) (year)

Cemetery or crematory St. Barnabas Epis.

Location Leeland, Md.

18. Funeral director Ritchie Brothers

Address Upper Marlboro, Md.

19. Aug 6 1940 Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 4 1940, at 8:58 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1939 to Aug 4 1940, and that I last saw h alive on Aug 3 1940.

Immediate cause of death	DURATION
Uraemia	
Due to Cardio vascular renal disease	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE James H. Boyle M. D. or other

Address Forestville Md Date signed Aug 4-40

RECEIVED
SEP 5 1940
BUREAU V. S.

STATE OF MARYLAND—CERTIFICATE OF DEATH

08789

93-d

V. S. No. 1

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1. PLACE OF DEATH

County Prince George Registration Dist. No. 239

If village or City Laurel Ward

No. St., (If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred 79 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

2. FULL NAME Ellen Mitchell

(a) Residence: No. 8th St., Ward. If nonresident give city or town and State

(Usual place of abode)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
Female	Colored	Widow

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Peter Mitchell

6. DATE OF BIRTH (month, day, and year) Aug 4 1861

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
78	11	29	

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc.

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc. Home Wife

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) Prince George Co
(State or country) Near Laurel

FATHER

13. NAME Unknown

14. BIRTHPLACE (city or town)
(State or country) Unknown

MOTHER

15. MAIDEN NAME Unknown

16. BIRTHPLACE (city or town)
(State or country) Unknown

17. INFORMANT Pearl Matthews
(Address) 90 1st Laurel, Md.

18. BURIAL, CREMATION, OR REMOVAL
Place Mountcastle Cem. Date Aug 6, 1940

19. UNDERTAKER Ridgley Selby
(Address) 401 East 1st Laurel Md

20. FILED Aug 5, 1940 M. Brashears
Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH 8 (Month) 2 (Day) 1940 (Year)

22. I HEREBY CERTIFY, That I attended deceased from 7 20, 1940, to 8 2, 1940

I last saw her alive on 8 2, 1940; death is said to have occurred on the date stated above, at 10:30 a.m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

	Date of onset
Ulcer Myocarditis	7.1.39
Acute Conjestion	
Dehydration	8.2.40

Other Contributory Causes of importance:

Name of operation Date of

What test confirmed diagnosis? Was there an autopsy? No

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? Date of injury, 19

Where did injury occur? (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of Injury

Nature of Injury

24. Was disease or injury in any way related to occupation of deceased? No

If so, specify

(Signed) B. A. Warren M. D.

(Address) Laurel Md

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as **at school** or **at home**. For a woman whose only occupation was that of home **housework**, write **housewife** in answer to Question 8 and **own home** in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as **servant—private family, cook—hotel**, etc. For a person who had no occupation whatever write **none**.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as **spinner, weaver**, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as **grocery store, soap factory, cotton mill**, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as **civil engineer, mechanical engineer, mining engineer, stationary engineer**, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as **carpenter, painter, machinist**, etc. Distinguish carefully between **retail merchants** and **wholesale merchants**. A person who sells goods should be called a **salesman** and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Auto[illegible] collision	*1 week ago*
Run over by street car	*1 week ago*
[illegible]	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

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ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08790

Reg. Dist. No. 238

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Prince Georges

City or town Capitol Heights

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Res. Capitol Terrace

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) Life

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Prince Georges

City or town Oxon Hill Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. Rt. 1 Baynes Farm

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME George Ralph Proctor

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 29, 1940

8. AGE: Years | Months 4 | Days 2 | If less than one day hrs. min.

9. Birthplace Freedmans Hospital D.C.
(Town, county, and state)

10. Usual occupation none

11. Industry or business

FATHER 12. Name Amos E. Proctor

FATHER 13. Birthplace Maryland

MOTHER 14. Maiden name Irene D. Proctor

MOTHER 15. Birthplace Maryland

16. Informant Irene Proctor

Address Oxon Hill Md

17. Wash. D.C. (Burial, cremation, or removal. Which?) Date thereof 8-3-40. (month) (day) (year)

Cemetery or crematory

Location

18. Funeral director John S. Rhines & Co.

Address 901-3 St. S.W.

19. 8/2 (Date rec'd by registrar) 19 40 Harvey Eagles Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 1 1940, at 2P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19, to 19, and that I last saw h alive on 19.

Immediate cause of death	DURATION
Dehydration	
Exhaustion	
Due to Acute Gastero enteritis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy none

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE [signature] M. D. or other

Address Forestville Md Date signed 8-1-40

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MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore
170-C

08791

CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH:
County: Prince Georges
City or town: Bladensburg
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Route #1
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days): Transient

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: North Carolina County: Mecklenburg
City or town: Charlotte Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 3801 - North Poplar St.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Robert Herman Robinson
3. (b) Social Security Number: 241-03-1221

4. Sex: Male
5. Color or race: White
6. (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.): Aug 17, 1913
8. AGE: Years 27 Months 0 Days 14 If less than one day hrs. min.
9. Birthplace: Union County N. C. (Town, county, and state)
10. Usual occupation: Truck Driver
11. Industry or business: Hauling
FATHER
12. Name: W. W. Robinson
13. Birthplace: Union County N. C.
MOTHER
14. Maiden name: Hettie Blythe
15. Birthplace: Union Co. N. C.
16. Informant: J. H. Butler
Address: 300 East Crode St Charlotte N.C.
17. Removal (Burial, cremation, or removal, Which?) Date thereof 8-31-40 (month) (day) (year)
Cemetery or crematory: McEwen Funeral Home
Location: Matthews, Mecklenburg Co., N. C.
18. Funeral director: F. Gasch's Sons
Address: Hyattsville, Md.
19. Aug 31 1940 (Date rec'd by registrar) G. Mrs Norgle Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 30 1940, at 11:15 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 , to 19 ,
and that I last saw h alive on 19 .

Immediate cause of death: Shock
Due to: Universal 3rd and 4th degree burn of body
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

DURATION

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of 8-30-40
Where did injury occur? Bladenburg Pr Geo Md (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) State Road
Means of injury: Auto collided & caught on fire Injured at work? Yes

23. SIGNATURE: James D. Boyd M. D. or other
Address: Forestville Md Date signed 8-31-40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08792

Reg. Dist. No. 243

1. PLACE OF DEATH: Prince George

County

City or town Glenn Dale
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 yr. 11 mos. 21 das

Hospital, institution, or street address where death occurred: Glenn Dale Sanatorium

How long in hospital or institution? 1 yr. 11 mos. 21 das

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State District of Columbia County

City or town Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 3329 Q. St., N.W.
(If rural, give LOCATION)

2.(a) If veteran, name war no

3. (a) FULL NAME Robertta Robinson

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Single

6.(b) Name of husband or wife —

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 30, 1923

8. AGE:

Years	Months	Days	If less than one day
17	2	21	— hrs. — min.

8. Birthplace Washington, D.C.
(Town, county, and state)

10. Usual occupation Student

11. Industry or business

FATHER
12. Name Walter Robinson
13. Birthplace Unknown

MOTHER
14. Maiden name Alberta Carpenter
15. Birthplace Howe's Hill, Va.

16. Informant deceased

Address above

17. Removal
(Burial, cremation, or removal. Which?)

Date thereof Aug 21-1940
(month) (day) (year)

Cemetery or crematory

Location Washington D.C.

18. Funeral director George W. Lewis

Address 2032-8th Street N.W.

19. Aug 21 1940
(Date rec'd by registrar)

Leo V. Schneider M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 21 1940, at 2:30 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 30 1938, to Aug 21 1940 and that I last saw her alive on Aug. 21 1940

Immediate cause of death Pulmonary Tuberculosis

DURATION about 2 yr 2 mos.

Due to

Due to

Other conditions None
(Include pregnancy within 3 months of death)

Major findings of operations none

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Daniel Leo Finucane M.D.
M. D. or other

Address Glenn Dale Sanatorium Date signed 8/21/40

Glenn Dale Md.

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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(M)

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08793

Reg. Dist. No. 243

1. PLACE OF DEATH:

County: Prince George

City or town: Glenn Dale
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 yr. 6 mo.

Hospital, institution, or street address where death occurred: Glenn Dale Sanatorium

How long in hospital or institution? 1 yr. 6 mo.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D.C. County: ✓

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1422 Wisconsin ave., N.W.
(If rural, give LOCATION)

2.(a) If veteran, name war: —

3. (a) FULL NAME: John Shepherd

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife: —

6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): Apr. 29, 1913

8. AGE:

Years	Months	Days	If less than one day
27	3	2	..... hrs. ..... min.

9. Birthplace: Arlington, Va.
(Town, county, and state)

10. Usual occupation: Truck driver

11. Industry or business: Dairy

FATHER
12. Name: James Samuel Shepherd
13. Birthplace: Landon Co., Va.

MOTHER
14. Maiden name: Blanche Cleveland
15. Birthplace: Fairfax Co., Va.

16. Informant: Deceased

Address:

17. Removal (Burial, cremation, or removal. Which?) Date thereof: Aug 1, 1940 (month) (day) (year)

Cemetery or crematory:

Location:

16. Funeral director: Geo W. Wise Co. Inc.

Address: 2900 M st N.W. Wash. D.C.

19. Aug. 1 1940 (Date rec'd by registrar) Leo V. Schneide M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 1 1940 at 4:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 9, 1939, to Aug 1 1940 and that I last saw him alive on Aug. 1 1940

Immediate cause of death	DURATION
Pulmonary Tuberculosis	1 yr. 9 mo.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op.

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D. M. D. or other

Address: Glenn Dale Sanatorium Glenn Dale Md. Date signed: 8/1/40

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08794

Reg. Diat. No. 243

1. PLACE OF DEATH:

County: Prince George

City or town: Glenn Dale

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 mo. 27 da.

Hospital, Institution, or street address where death occurred: Glenn Dale Sanatorium.

How long in hospital or Institution? 1 mo. 27 da.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1617 Swann St. N.W.

(If rural, give LOCATION)

2.(a) If veteran, name war: —

3. (a) FULL NAME: Alverda Shorts

3. (b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	married

6.(b) Name of husband or wife: Wilton Shorts

6.(c) If alive, give age: 33 years

7. Birth date of deceased (mo., day, yr.): July 15, 1907

8. AGE: Years: 33 | Months: 1 | Days: 14 | If less than one day: ...hrs. ...min.

9. Birthplace: Charlotte Hall, Md.

(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Home

FATHER — 12. Name: Philip Tolston

FATHER — 13. Birthplace: Charlotte Hall, Md.

MOTHER — 14. Maiden name: Grace Heater

MOTHER — 15. Birthplace: Charlotte Hall, Md.

16. Informant: deceased

Address: —

17. Removal (Burial, cremation, or removal. Which?) Date thereof: Aug. 29, 1940 (month) (day) (year)

Cemetery or crematory:

Location: Washington D.C.

18. Funeral director: [illegible]

Address: 1432 [illegible] St N.W.

19. August 29 40 (Date rec'd by registrar) Leo V. Almeda M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 29 1940, at 2:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 2 1940, to Aug 29 1940

and that I last saw h.e.r. alive on Aug 1 29 1940

Immediate cause of death	DURATION
Pulmonary Tuberculosis	1 yr.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op.:

Autopsy results: Pulmonary Tuberculosis

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: ... Injured at work?

23. SIGNATURE: Daniel Lee Finucane M.D. M. D. or coroner

Address: Glenn Dale Sanatorium Date signed: 8/29/40

Glenn Dale Md.

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

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BUREAU V. S.

08795

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-E)

CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH:

County: Prince George

City or town: Glenn Dale
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 mo. 27 days.

Hospital, institution, or street address where death occurred: Glenn Dale Sanatorium

How long in hospital or institution? 1 mo. 27 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1246 Union Court, S.W.
(If rural, give LOCATION)

2.(a) If veteran, name war: —

3. (a) FULL NAME: William Snowden

3. (b) Social Security Number: 579-16-3585

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	single

6.(b) Name of husband or wife: —

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Dec. 5, 1895

8. AGE:

Years	Months	Days	If less than one day
44	7	29	..... hrs. ..... min.

9. Birthplace: Washington, D. C.
(Town, county, and state)

10. Usual occupation: laborer

11. Industry or business: —

FATHER
12. Name: Warner Snowden
13. Birthplace: Md.

MOTHER
14. Maiden name: Alice Snowden
15. Birthplace: Md.

16. Informant: deceased

Address: —

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 7, 1940 (month) (day) (year)

Cemetery or crematory: cemetery

Location: Washington D.C.

18. Funeral director: John T. Rhines & Co.

Address: 901-3rd. St. S.W.

19. Aug 4 1940 (Date rec'd by registrar) Les V. Schneider M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 4 1940, at 9:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 7, 1940, to Aug 4 1940 and that I last saw him alive on Aug 4 1940

Immediate cause of death	DURATION
Tuberculous Pericarditis	2 mo.
Due to: Tuberculous Pleural Effusion	1 yr. 2 mo.
Due to:	
Other conditions	

(include pregnancy within 3 months of death)

Major findings of operations: none

Date of op.

Autopsy results: Tuberculous Pericarditis

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D. M. D. or other

Address: Glenn Dale Sanatorium Date signed: Glenn Dale, Md.

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (38)

CERTIFICATE OF DEATH

08796

Reg. Dist. No. 243

1. PLACE OF DEATH:
County: Prince George
City or town: Rural near Glenn Dale
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 yrs - 2 mos - 6 days
Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium
How long in hospital or institution? 2 yrs - 2 mos - 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D. C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3537-11th st. N.W.
(If rural, give LOCATION)
2.(a) If veteran, name war: —

3.(a) FULL NAME: Grace Sothoron

3.(b) Social Security Number: None-

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	married

6.(b) Name of husband or wife: Earl Sothoron
6.(c) If alive, give age: 50 years

7. Birth date of deceased (mo., day, yr.): 4/15/90

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
50	3	18		

9. Birthplace: Md.
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: —
12. Name of father: John H. Hopkins
13. Birthplace of father: Md.
14. Maiden name of mother: Elizabeth Ann Sullivan
15. Birthplace of mother: Md
16. Informant: Deceased
Address: —
17. (Burial, cremation, or removal. Which?) Removal — Date thereof: 8/3/40 (month) (day) (year)
Cemetery or crematory:
Location: Washington D.C.
18. Funeral director: Wood Chambers Co
Address: 1400 Chapin St. N.W. Washington D.C.
19. 8-3 1940 (Date rec'd by registrar) — Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 3 1940 at 2.10 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5/27 1938 to 8/3 1940 and that I last saw h.r alive on 8/3/40 1940

Immediate cause of death	DURATION
Pulmonary Tuberculosis	17 yrs
Due to: —	
Due to: —	
Other conditions: —	

(Include pregnancy within 3 months of death)

Major findings of operations: —
Date of op.: —
Autopsy results: No autopsy
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: — Date of: —
Where did injury occur? — (City or town) — (County) — (State)
Injured at home, farm, industry, public place (where?): —
Means of injury: — Injured at work?

23. SIGNATURE: Daniel Lee Finucane M.D.
M. D. or other
Address: Glenn Dale Sanatorium Date signed: 8/7/40
Glenn Dale, Md

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SEP 2 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

CERTIFICATE OF DEATH

08797

Reg. Dist. No. 230

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Prince georges
City or town Berwyn
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: 1st and B Sts.
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 21 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Prince georges
City or town Berwyn Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 1st and B Sts.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Bertha M. Stallings

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	married

B (b) Name of husband or wife Charles B. Stallings
6(c) If alive, give age 61 years

7. Birth date of deceased (mo., day, yr.) Sept. 16, 1873

8. AGE: Years	Months	Days	If less than one day
66	10	21	hrs. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business Own home
FATHER 12. Name
13. Birthplace Unknown
MOTHER 14. Maiden name
15. Birthplace Unknown
16. Informant Charles B. Stallings
Address Berwyn, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 10, 1940 (month) (day) (year)
Cemetery or crematory Ft. Lincoln
Location Bladensburg, Md.
18. Funeral director W. W. Chambers Co.
Address Riverdale, Md.
19. Aug 7th 1940 (Date rec'd by registrar) John D Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 7, 1940, at 11:15 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1, 1940, to Aug 7, 1940, and that I last saw her alive on Aug 5, 1940.

Immediate cause of death	DURATION
Cardio vascular renal disease (Uremia)	
Due to Chronic glomerular nephritis	
Due to	
Other conditions Diabetes Arteriosclerosis	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE H. G. Payne M.D. M. D. or Other
Address 3629-34 St Date signed 8-1-40
Mt. Rainier Md.

RECEIVED
SEP 4 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08798

Reg. Dist. No. 246

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Prince Georges
City or town Mt Rainier
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: 3708-33rd St Mt Rainier Md.
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 2 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Pr Georges
City or town Mt Rainier Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 3708 - 33rd
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Neil Paul Thiele

3. (b) Social Security Number 578-07-9113

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Mary Kathryn
6(c) If alive, give age 34 years

7. Birth date of deceased (mo., day, yr.) Aug. 24th 1902

8. AGE: Years 38 | Months — | Days 4 | If less than one day ____ hrs. ____ min.

9. Birthplace Newark, N. J.
(Town, county, and state)

10. Usual occupation Battery Foreman

11. Industry or business

FATHER
12. Name Herman P. Thiele
13. Birthplace Brooklyn, N. Y.

MOTHER
14. Maiden name Amelia F. Bast
15. Birthplace Brooklyn, N. Y.

16. Informant Mary Kathryn Thiele
Address 3708 - 33rd St. Mt. Rainier Md

17. Burial Date thereof Aug 30th 1940
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Fort Lincoln
Location Bladensburg Road Md.

18. Funeral director Wm J Talley
Address 3200 R.I. Ave Mt Rainier Md.

19. Aug 29 1940 Wm J Talley Reg'd
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 28 1940, at 1:35 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 15 1940, to Aug. 28 1940, and that I last saw him alive on Aug. 27 1940 1940.

Immediate cause of death	DURATION
tuberculous pneumonia	4 days
Due to widespread pulmonary tuberculosis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Daniel B. Washington MD
M. D. or other
Address 6234 Ga Ave Wash DC Date signed 8/28/40

RECEIVED
SEP. 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(51-B)

08799

CERTIFICATE OF DEATH

Reg. Dist. No. 231

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Prs Geo Co
City or town: Berwyn Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 32 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Prs Geo Co
City or town: Berwyn Md
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: no

3. (a) FULL NAME: Frederick Kenyon Triffe

3. (b) Social Security Number: no.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	widower

6.(b) Name of husband or wife: mary K Triffe

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
75 yrs			..... hrs. ..... min.

9. Birthplace: mass (Town, county, and state)

10. Usual occupation: Artist

11. Industry or business

FATHER 12. Name: Hiram Bradford

13. Birthplace: mass

MOTHER 14. Maiden name: sallie white

15. Birthplace: ?

16. Informant: Blanche Bradford

Address: Berwyn Md

17. (Burial, cremation, or removal. Which?) Rock Creek Burial Date thereof: Aug 7 1940 (month) (day) (year)

Cemetery or crematory: Rock Creek

Location: Washington D C

18. Funeral director: F Gasch's sons

Address: Hyattsville Md

19. Aug 6 1940 (Date rec'd by registrar) Wm Monroe Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 5 1940, at 12.15 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 2 1940, to August 5 1940

and that I last saw him alive on August 4 1940

Immediate cause of death ..... DURATION

Cancer of Prostate ..... 1½ years

Due to .....

Due to .....

Other conditions .....

(Include pregnancy within 3 months of death)

Major findings of operations .....

Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work? —

23. SIGNATURE: Mrs. Allen Griffith M. D. or other

Address: Berwyn Md Date signed: Aug 6 1940

RECEIVED
SEP 4 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 89-a

CERTIFICATE OF DEATH

08800

Reg. Dist. No. 2 X 6

Pr. George's

1. PLACE OF DEATH:
County 3910 - 30th St. NE.
City or town Mt. Ranier Md
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 30 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Prince George
City or town Hyattsville Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 3910 - 30
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Mary C Walsh

3. (b) Social Security Number

4. Sex: Female
5. Color or race: White
6. (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Feb. 14 - 1856
8. AGE: Years 84 | Months 6 | Days 15 | If less than one day hrs. min.
9. Birthplace Ireland (Town, county, and state)
10. Usual occupation At Home
11. Industry or business
FATHER 12. Name Thomas R. Walsh
13. Birthplace Ireland
MOTHER 14. Maiden name Catherine Galvin
15. Birthplace Ireland
16. Informant Stephen A Walsh
Address 3910 - 30th St. N.E.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 31 - 1940 (month) (day) (year)
Cemetery or crematory Mt. Olivet Cemetery
Location Washington D.C.
18. Funeral director Perry & Walsh
Address 29 - H St. N.W. Wash. D.C.
19. Aug 29 1940 Henry Walsh Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH August 29 1940, at 12:45 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 2 1939, to Aug. 29 1940, and that I last saw h-- alive on August 28 1940.

	DURATION
Immediate cause of death: Cerebral hemorrhage	2 wks.
Due to: Vascular accident	
Due to	
Other conditions: Arteriosclerosis	

(Include pregnancy within 3 months of death)

Major findings:
Of operations —
Of autopsy —

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE R. L. Payne M.D. M. D. or other
Address 3629 - 34 St. Date signed 8-29-40
Mt. Rainier, Md.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

RECEIVED
SEP 5 1968
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-C)

CERTIFICATE OF DEATH

08801

Reg. Dist. No. 243

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Prince Georges
City or town Rural Nr Glenn Dale.
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Glenn Dale Sanatorium
Stay in hospital or inst. (yrs., or mos., or days) 1 yr - 2 mos - 11 days
Stay in this community (yrs., or mos., or days) Same -

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State D C County
City or town Washington Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 2311 - Wisconsin Ave N.W
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR ✓

3. (a) FULL NAME Martha Virginia Wallin

3. (b) Social Security Number none -

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife: Wm Wallace Wallin

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Nov - 30 - 1884

8. AGE: Years	Months	Days	If less than one day
55	8	3	____ hrs. ____ min.

9. Birthplace Miami MO.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business ____

FATHER 12. Name Philander Gibbons

FATHER 13. Birthplace Va.

MOTHER 14. Maiden name Susan E. Collins

MOTHER 15. Birthplace Ky.

16. Informant Husband
Address

17. Removal (Burial, cremation, or removal. Which?) Date thereof 8/3/40 (month) (day) (year)

Cemetery or crematory ____

Location Washington D.C.

18. Funeral director Joseph Gawler & Sons.

Address 1756 Penna. Ave. N. W.

19. Aug 3 (Date rec'd by registrar) 19 40 Le. V. Almeida M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 2 1940, at 6 35 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 13 - 1939, to Aug - 2 - 1940, and that I last saw h tr alive on Aug 2 - 1940.

Immediate cause of death	DURATION
(a) Pulmonary Tuberculosis	1 yr - 9 mo
Due to (b) ____	
Due to (c) ____	
Other conditions ____	

(Include pregnancy within 3 months of death)

Major findings:
Of operations ____
Of autopsy Pulmonary Tuberculosis

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: —
Accident, suicide, or homicide ____ Date of ____
Where did injury occur? ____ (City or town) ____ (County) ____ (State)
Injured at home, farm, industry, public place (where?) ____
Means of injury ____ Injured at work? ____

23. SIGNATURE Daniel Lee Prince M.D.
M. D. or other
Address Glenn Dale Sanatorium Date signed
Glenn Dale, Md.

RECEIVED
SEP 2 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08802

Reg. Dist. No. 243

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Prince Georges

City or town: Glenn Dale

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 days

Hospital, institution, or street address where death occurred: Glenn Dale Sanatorium

How long in hospital or institution? 7 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 928 - 3rd St. N. W

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME: CLAUDIUS WRIGHT

3. (b) Social Security Number: 577-16-4786

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	Separated

6.(b) Name of ~~husband or~~ wife: Fanell Parker

6.(c) If alive, give age: 27 years

7. Birth date of deceased (mo., day, yr.): July 12, 1911

8. AGE: Years	Months	Days	If less than one day
29	1	10	...hrs. ...min.

9. Birthplace: Washington D.C. (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business:

FATHER

12. Name: Claudius Wright Sr.

13. Birthplace: South Carolina

MOTHER

14. Maiden name: Lizzie Gibson

15. Birthplace: South Carolina

16. Informant: Deceased.

Address

17. Removal (Burial, cremation, or removal. Which?) Date thereof: Aug 23, 1940 (month) (day) (year)

Cemetery or crematory:

Location: Washington, D.C.

18. Funeral director: Tolbert Funeral Home

Address 1308 - 6th St., n.w. Washington, D.C.

19. Aug 23 1940 (Date rec'd by registrar) Leo V. Kilmeade M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 22 1940, at 9:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 15 1940, to Aug 22 1940 and that I last saw h...alive on August 22 1940

Immediate cause of death	DURATION
Pulmonary Tuberculosis	9 mo.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results: Pulmonary Tuberculosis.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D. M. D. or other

Address: Glenn Dale Sanatorium Date signed: 8/24/40

Glenn Dale, Md.

RECEIVED
SEP 2 1940
BUREAU V. S.

08803

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93-L

CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH:

County: Prince Georges Co.

City or town: Riggs Dr Hyattsville Md.
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Mother Jones Rest Home.

Stay in hospital or inst. (yrs., or mos., or days): I Mo I4 Days.

Stay in this community (yrs., or mos., or days): I Mo I4 Days.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington, D. C. Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: 7809 Morningside Drive
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Anna Zetterlund.

3. (b) Social Security Number:

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Female	White	Single.

6 (b) Name of husband or wife:

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): June I5 I8 69

8. AGE: Years	Months	Days	If less than one day
71	1	27	____ hrs. ____ min.

9. Birthplace: Sweden.
(Town, county, and state)

10. Usual occupation: Maid

11. Industry or business:

FATHER
12. Name: Unknown
13. Birthplace: Sweden

MOTHER
14. Maiden name: Unkown.
15. Birthplace: Sweden.

16. Informant: Mrs Gilbert.
Address: 7908 Morningside Drive.N.W.

17. Washington.D.C. Date thereof: 8/I2/40
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory: Of Lincoln Cemetery

Location:

18. Funeral director: M. G. Huntemann
Address: 5732 Georgia Ave N.W.

19. August 12 1940 Mrs Jas. Severe
(Date rec'd by registrar) Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 12 1940, at 14 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 15 1940, to Aug 12 1940, and that I last saw her alive on Aug 12 1940.

Immediate cause of death	DURATION
Acute Cardiac Dilatation	
Due to Chr. Nyo. [illegible]	?
Due to Hy. Veterinary	?
Other conditions Arthr. Sclerosis	?

(Include pregnancy within 3 months of death)

Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Martin [illegible] M. D. or other
Address: [illegible] Date signed:

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
SEP 5 1940
BUREAU V. S.